General Assembly

Raised Bill No. 34

February Session, 2016

LCO No. **462**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING DISPENSATION AND COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC DISEASE DURING CERTAIN ADVERSE DETERMINATION REVIEWS, AND DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 38a-591d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(b) With respect to a nonurgent care request:

(1) (A) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than fifteen calendar days after the date the health carrier receives such request, and shall notify the covered person and, if applicable, the covered person's authorized representative of such determination, whether or not the carrier certifies the provision of the benefit.

(B) If the review under subparagraph (A) of this subdivision is a review of a grievance involving a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(C) (i) If the review under subparagraph (A) of this subdivision is a review of a grievance involving a prospective review request relating to the dispensing of a drug for a chronic disease, other than a schedule II or III controlled substance, that is prescribed by a licensed participating provider who is a specialist in such chronic disease, the health carrier shall issue an electronic authorization to the covered person's pharmacy for the dispensing of a temporary supply of such drug sufficient for the duration of such review until the covered person has been notified of the review decision. Such authorization shall include confirmation of the availability of payment for such supply of such drug.

(ii) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with such participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such participating provider does not concur, the health carrier shall cancel such authorization.

(iii) The provisions of this subparagraph shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such

request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

Sec. 2. Subsection (c) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the clinical peer or peers involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) The clinical peer or peers conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are

submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge, by facsimile, electronic means or any other expeditious method available, to the covered person or the covered person's authorized representative, as applicable, any new or additional documents, communications, information and evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such documents, communications, information, evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review request, pursuant to 45 CFR 147.136, as amended from time to time, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(4) (A) If the review under subdivision (1) of this subsection is a review of a grievance involving a prospective review request relating to the dispensing of a drug for a chronic disease, other than a schedule II or III controlled substance, that is prescribed by a licensed

participating provider who is a specialist in such chronic disease, the health carrier shall issue an electronic authorization to the covered person's pharmacy for the dispensing of a temporary supply of such drug sufficient for the duration of such review until the covered person has been notified of the review decision. Such authorization shall include confirmation of the availability of payment for such supply of such drug.

(B) Not later than twenty-four hours after the health carrier has issued such authorization to the pharmacy and prior to the pharmacy's dispensation of such drug, such health carrier shall confirm with such participating provider the provider's concurrence with the dispensing of such temporary supply of such drug. If such participating provider does not concur, the health carrier shall cancel such authorization.

(C) The provisions of this subdivision shall not apply to a grievance or review of an adverse determination under this section concerning the substitution of a generic drug or another brand name drug for a prescribed brand name drug unless the prescribing licensed participating provider has specified that there shall be no substitution for the specified brand name drug.

Sec. 3. Subdivision (1) of subsection (c) of section 38a-591d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(1) (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than **[**seventy-two**]** forty-eight hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the

number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

(B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

Sec. 4. Subdivision (1) of subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance;

(C) For expedited review requests, except as specified under subparagraph (D) of this subdivision, **[**seventy-two**]** forty-eight hours after the health carrier receives the grievance; and

(D) For expedited review requests of a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, twenty-four hours after the health carrier receives the grievance.

Sec. 5. Subdivision (1) of subsection (i) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, except as specified under subparagraph (D) of this subdivision, as expeditiously as the covered person's medical condition requires, but not later than **[**seventy-two**]** forty-eight hours after such organization receives the assignment from the commissioner to conduct such review;

(D) For expedited external reviews involving a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as expeditiously as the covered person's medical condition requires, but not later than twenty-four hours after such organization receives the assignment from the

commissioner to conduct such review; and

(E) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	38a-591d(b)
Sec. 2	*January 1, 2017*	38a-591e(c)
Sec. 3	*January 1, 2017*	38a-591d(c)(1)
Sec. 4	*January 1, 2017*	38a-591e(d)(1)
Sec. 5	*January 1, 2017*	38a-591g(i)(1)

Statement of Purpose:

To establish procedures for the dispensation of and coverage for a prescribed drug for a chronic disease during certain adverse determination reviews, and decrease the time frame for urgent care adverse determination review requests from seventy-two hours to forty-eight hours.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]